



PATIENT INTAKE FORM

Patient Information:

Name Phone () DOB
Address City State Zip
Email Referral Source
Emergency Contact Phone ()

General Medical Information:

Occupation Referring MD, DC, ND
Health Insurance Carrier ID#
Group# Phone () would you like us to check your benefits

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms massage/bodywork may be contraindicated. A referral from a doctor may be required prior to services being provided.

- Yes No Have you ever received a professional massage? How recently?
Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you suffer from Headaches/Migraines?
Yes No Are you pregnant?
Yes No Do you suffer from arthritis?
Yes No Do you wear contact lenses?
Yes No Are you wearing dentures?
Yes No Do you have high blood pressure?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies?
Yes No Do you bruise easily
Yes No Have you had any broken bones in the past two years?
Yes No Do you have cardiac or circulatory problems
Yes No Injury or accident in the past 2 years?
Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pain anywhere?
Yes No Are you sensitive to pressure/touch in any area?
Yes No Do you have tension, pain, soreness in any particular area?
Yes No Have you ever had surgery?
Yes No Are you currently taking any medication/supplements?

If you answered YES to any of these questions please use the space below to elaborate.

Blank lines for patient response to the above questions.

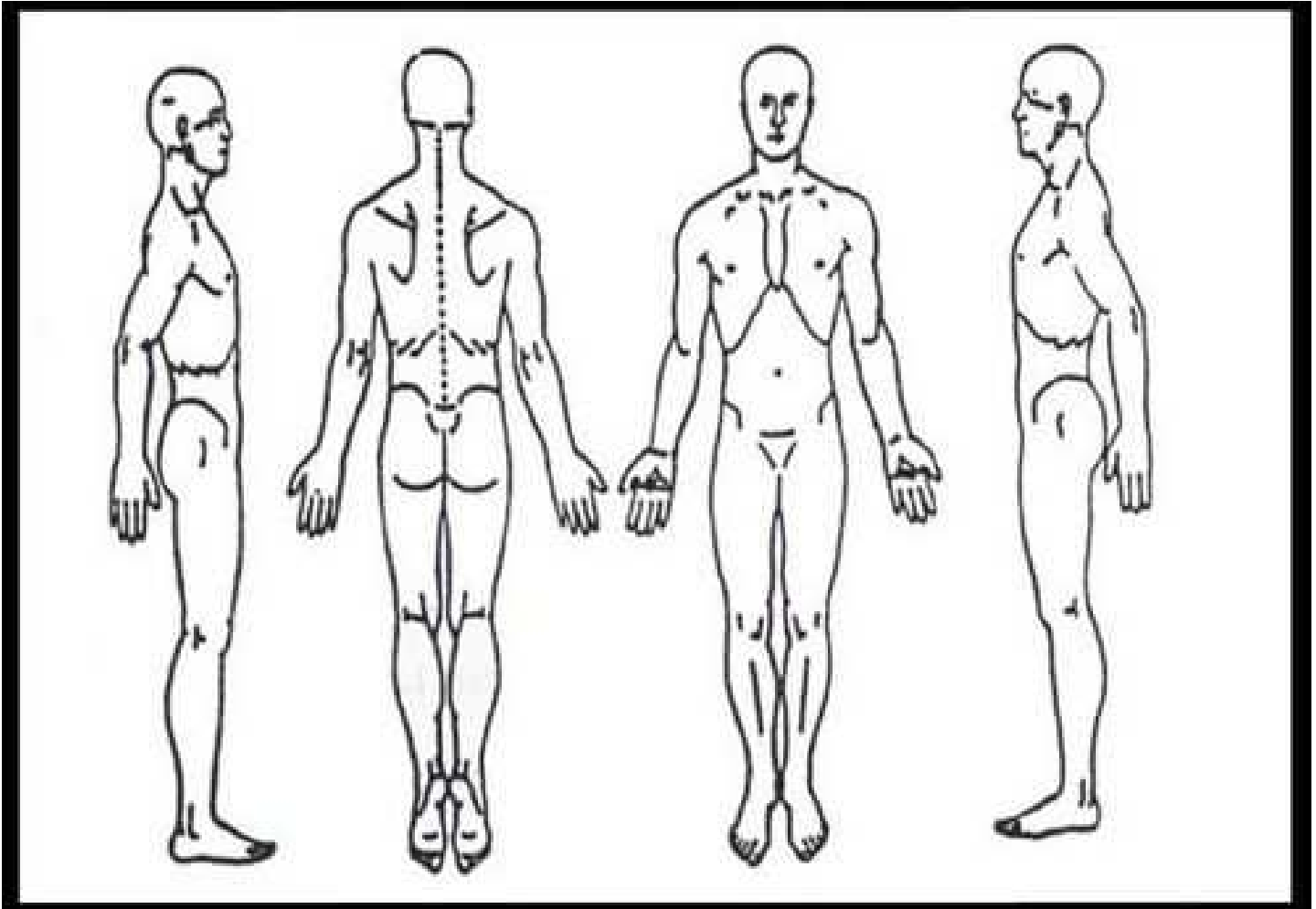
I understand that the Massage/Bodywork that I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the Practitioner so that the pressure/strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. And, that I should see a Physician, Chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that the Massage/Bodywork Practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because Massage/Bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep the Practitioners updated as to any changes in my medical profile and understand that there shall be no liability on the Practitioners part should I fail to do so. I also understand that elicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Patient Signature Date

Consent to Treatment of Minor: By my signature below, I hereby authorize any Practitioner at Unlocking The Body, Inc. to administer Massage/Bodywork, or Somatic Therapy techniques to my child or dependent as they deem necessary.

Parent/Guardian Signature Date

Identify **CURRENT** symptomatic areas in your body by **CIRCLING** areas of dysfunction.
Utilize the letters in the key below to identify type of symptom you are feeling in each **CIRCLED AREA**.



KEY:

P = Pain

T = Tenderness

I = Inflammation

N = Numbness/Tingling

S = Joint/Muscles Stiffness

Next to Each Circled Area Rate The Level of Discomfort on a 1 – 5 Scale, with 1 = Mild and 5 = Severe.

Signature

Date



FINANCIAL POLICY

Payment: As a patient of this office you are directly responsible for payment of all charges incurred while under treatment unless you are eligible for insurance reimbursement with an insurance carrier the Provider's have contracted with. Payments are due when services are rendered or supplies are received. If the Provider is contracted with your Insurance Carrier, all deductibles, co-pays, co-insurances, and previous balances that are the patient's responsibility are due *at the time of service*. Accepted methods of payments are: personal check, credit, and cash.

Insurance: If the Provider is contracted with your Insurance Carrier we will bill your insurance directly. We will make every effort to determine benefits and eligibility prior to treatment. What we are told by your Insurance Carrier will govern how we determine your liability. We are not responsible for payment discrepancies that might occur once the reimbursement check is received. It is the patient's responsibility to keep track of their deductible, maximum benefit, or other liabilities specific to their plan's coverage. If you are not covered by one of our contracted Carriers and think that your insurance will cover Massage Therapy or Acupuncture, at your request we will provide you with an insurance billing form that you may submit to receive payment from your insurance company.

Cancellations and No-Show Fees: Please give us at least 24 hours advance notice of your inability to keep an appointment. If less than 24 hours notice is received the amount of the scheduled visit will be charged directly to the patient to be paid before any further appointments will be scheduled. This is to discourage repeat "No-Show's" or late cancellations. If you must cancel less than 24 hours before your appointment feel free to discuss the nature of your cancellation with your Provider.

Authorization for Treatment

I, the undersigned, hereby acknowledge that the care being provided at Unlocking The Body, Inc. is designed to improve my health or condition. I authorize the release of any medical or other information necessary to process my claims. I authorize the Provider to perform treatment necessary for my care, including different styles of Massage Therapy, Acupuncture, Stretching, and Hydrotherapy procedures. When treatment is performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. I understand that every effort will be made by the office to fully disclose information about the procedures used. If I have questions about these procedures I will ask them until they are answered to my full satisfaction. I further acknowledge that there is no guarantee or warranty, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.

I understand and agree to the above Financial Policy and Authorization for Treatment. I will abide by its terms.

Signature of Patient

Date

Printed Name

Responsible Party



HIPAA AUTHORIZATION FORM

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

5 Law requires the privacy of your health information be maintained and that you are provided this notice of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures we described below, your health information will not be sold or provided to any outside marketing organization. We must abide by the terms of this notice and we reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in our files, and you will be notified in writing.

10 **HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

USES AND DISCLOSURES

Here are examples of use and disclosure of your health care information:

- 15 1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your session records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run this practice.
- 20 4. We may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, Welcome and Thank You cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

25 You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

30 Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

- 35 1. We are providing services to you based on the orders (referral) of a health care provider.
2. We provide services to you in an emergency and are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

40 You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

45 We will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

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INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect your files while in our office and/or have a copy made for you. The information is available up to seven years from the date that the record was created.

Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of \$.20 per page copied.

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ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

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Required for your session, to obtain payment for services, to run our practice, and/or made to you.

Necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.

For national security, intelligence purposes, or law enforcement officers.

That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

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We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

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We cannot control the actions of others to whom we have released your information for further treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

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You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

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This notice effective as of todays date signed below. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

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I, _____, give my permission for you to leave any information for me and use your name/clinic name at the following:

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Home Phone _____ Cell Phone _____

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Work phone _____ Fax _____

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Patient Signature

Date

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Authorized Staff Initials